

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

9154

09126

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> c. LENGTH OF STAY IN 1b <u>6 hours</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Weeks Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u> d. STREET ADDRESS <u>123 Church St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>RILEY</u> Last <u>BOSLEY</u>		4. DATE OF DEATH Month <u>8</u> / Day <u>14</u> / Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 25, 1877</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>14</u> Hours <u>19</u> Min. <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mine</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Bosley</u>		14. MOTHER'S MAIDEN NAME <u>Florence Liller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT <u>Mrs. William Bosley, Westernport, Maryland</u>		Address <u>                    </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arterio; sclerosis</u> DUE TO (c) <u>                    </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>                    </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>                    </u> p. m. <u>                    </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>                    </u>		20f. (City or town) <u>                    </u> (County) <u>                    </u> (State) <u>                    </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 4</u> 19 <u>60</u> to <u>Aug 13</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Aug. 13</u> 19 <u>60</u> , and that death occurred at <u>9PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>J.H. Wolverton, Sr.</u>		22b. DATE SIGNED <u>                    </u>	
22c. PHYSICIAN'S NAME (Type) <u>J.H. Wolverton, Sr</u>		22d. ADDRESS <u>Piedmont, West Va.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 17, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		23d. LOCATION (City, town, or county) <u>Westernport, Maryland</u> (State) <u>                    </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>E.S. Boal</u>		25a. REC'D BY REGISTRAR <u>                    </u> DATE <u>AUG 18 '60</u>	
ADDRESS <u>Westernport, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

090

1

BP

05100

CERTIFICATE OF DEATH

05100

1

DECLARATION OF DEATH

Signature of Declarant

Signature of Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9174

## CERTIFICATE OF DEATH

09127

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.D.2. SWANTON</b>			
				d. STREET ADDRESS <b>1</b>			
				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>SADIE GRACE DURST</b>				4. DATE OF DEATH Month Day Year <b>AUG 20 19 60</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 5, 1899</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>RICHARD BECKMAN</b>				14. MOTHER'S MAIDEN NAME <b>MARY E. PRITTS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>RAY DURST R.D. 2, SWANTON, MD,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ANGINA PECTORIS</b> <b>430.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Aug 13</b> , 19 <b>60</b> , to <b>Aug 20</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>AUG. 13</b> , 19 <b>60</b> , and that death occurred at <b>4 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>GREEN ST.</b> DATE SIGNED <b>8/20/60.</b>							
ACTUAL SIGNATURE <b>James H. Wolverton, Sr.</b> M.D.							
PHYSICIAN'S NAME (Type) <b>JAMES H. WOLVERTON, SR.</b> <b>PIEDMONT W.V.A.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>AUG. 22/60</b>		<b>NORTH GLADE CEMETERY</b>		<b>RT. 435 SWANTON MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Kline</b> ADDRESS <b>PIEDMONT, W.V.A.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 24 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kline</b>	



9155

## CERTIFICATE OF DEATH

09128

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) o. STATE <b>Garrett</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RURAL Oakland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cuppett Nursing Home</b>				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Addie Belle Eshelman</b>				4. DATE OF DEATH Month Day Year <b>Aug. 9, 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 11, 1879</b>	
9. AGE (In years last birthday) <b>80</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New Hampshire</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>George Howard</b>				14. MOTHER'S MAIDEN NAME <b>Luette Carpender</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Swager</b> Address <b>Mrs. Edith <del>XXXXXX</del> Oakland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral vascular accident March 1960</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>  <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>3-6-60</b> , 19____, to <b>8-8-60</b> , 19____, that I last saw the deceased alive on <b>8-8-60</b> , 19____, and that death occurred at <b>8 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>58 2nd. St., Oakland, Md.</b> DATE SIGNED <b>8-9-60</b>							
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b> M.D.							
PHYSICIAN'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b> <b>58 2nd. St., Oakland, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/11/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Davis</b>		22d. LOCATION (City, town, or county) (State) <b>Davis W.Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wayne C. Flizzle</b> ADDRESS <b>Davis, W.Va.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9156

CERTIFICATE OF DEATH

09129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>68 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Fourth Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John McClellan Falkenstein</b>		4. DATE OF DEATH Month <b>August</b> Day <b>13</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 25, 1862</b>
9. AGE (In years last birthday) <b>98</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ethbell Falkenstein</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Feather</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Miss Grace Falkenstein</b>		Address <b>Oakland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dehydration + Uremia</b> <b>561.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Intestinal Obstruction</b> DUE TO (c) <b>Incarcerated right Femoral Artery</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b> <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Advanced Arteriosclerotic Cardiovascular Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1959</b> to <b>Aug 13, 1960</b> , that I last saw the deceased alive on <b>Aug 13, 1960</b> , and that death occurred at <b>3:30P M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert H. Leighton</b> M.D.		ADDRESS (Street, city or town, state) <b>77 Oak St., Oakland, Md.</b>	
DATE SIGNED <b>Aug 60</b>			
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M. D.</b>		<b>Oakland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/16/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oakland, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Leighton</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D BY REGISTRAR <b>AUG 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

9175  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**  
Item 14 Film 268 8-9-60 et

09130

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>W.Va.</b> b. COUNTY <b>KANAWHA</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BLOOMINGTON</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Belle</b>		
c. LENGTH OF STAY IN TB —			d. STREET ADDRESS —		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) —			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>LEE</b> Last <b>FARMER</b>			4. DATE OF DEATH Month <b>AUG.</b> Day <b>2nd.</b> Year <b>19 60</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 23, 1938</b>	9. AGE (In years last birthday) <b>21</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>DOW CHEMICAL</b>		11. BIRTHPLACE (State or foreign country) <b>W.Va.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Camillus FARMER</b>		
14. MOTHER'S MAIDEN NAME <b>"Unobtainable"</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. —			17. INFORMANT Address —		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CRUSHED SKULL</b> <b>816X</b> DUE TO <b>BROKEN LEGS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MULTIPLE EXTENSIVE CHEMICAL BURNS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b> <b>II</b> <b>II</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Tractor-trailer loaded with acid wrecked at bottom of Rt. 135 at Bloomington, Maryland.</b> <i>(Struck parked truck)</i>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>5:05</b> p.m. <b>8-2-60</b> 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>	
20f. (City or town) <b>Bloomington Garr., Md.</b>		20g. (County) —		20h. (State) —	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>JAMES H. FEASTER, JR., M. D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <b>8-2-60</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>			22b. DATE THEREOF <b>Aug. 2, 1960</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>WESTERNPORT, Md.</b>			22d. LOCATION (City, town, or country) (State) <b>EAST BANK, W.Va.</b>		
23. FUNERAL DIRECTOR <b>E. S. Beral</b>			ADDRESS <b>Westernport, Md.</b>		
24a. REC'D BY REGISTRAR <b>AUG 4 '60</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>		

MEDICAL CERTIFICATION

00130

FOR NAME  
FOR NAME



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9157

## CERTIFICATE OF DEATH

09131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Greene</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>8 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cuppett Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John</b> First <b>Gillivan</b> Middle <b>L</b> Last		4. DATE OF DEATH Month <b>8</b> Day <b>28</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1886</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>mining</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>unk.</b>	
13. FATHER'S NAME <b>unk.</b>		14. MOTHER'S MAIDEN NAME <b>unk.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>286-05-1690</b>	
17. INFORMANT <b>Cuppett Nursing Home</b>		Address <b>Oakland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemiplegia</b> <b>352X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Malnutrition - Chronic Asthma</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr. 1957</b> , to <b>Aug. 28, 1960</b> , that I last saw the deceased alive on <b>Aug. 27, 1960</b> , and that death occurred at <b>2 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>25 ARDEN ST</b> DATE SIGNED <b>8/29/60</b>			
ACTUAL SIGNATURE <b>E. L. Baumgartner</b>		M.D. <b>Z. S. ARDEN ST</b>	
PHYSICIAN'S NAME (Type) <b>E. L. BAUMGARTNER</b>		<b>OAKLAND, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>8/30/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Oakland Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gerald N. Minnich</b>		ADDRESS <b>Oakland, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Evans</b>	

THE COMMISSION  
TAIN BOND

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Time of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar		11. Signature of witness	
John Doe		Male		45		1945		10:00 AM		Home		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
12. Name of informant		13. Relationship		14. Address		15. City		16. State		17. Zip		18. Date of birth		19. Sex		20. Age		21. Signature of informant		22. Signature of registrar	
Jane Doe		Wife		123 Main St		Baltimore		Maryland		21201		1900		Female		35		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

9158

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09132

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>21 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett Co. Memorial Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Oakland</b>	
3. NAME OF DECEASED (Type or print) First <b>Dewey</b> Middle <b>Elwood</b> Last <b>Gnegy</b>		4. DATE OF DEATH Month <b>August</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-6-xx 1898</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months <b>13</b> Days <b>13</b> Hours <b>13</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>America U.S.A.</b>	
13. FATHER'S NAME <b>Joel Gnegy</b>		14. MOTHER'S MAIDEN NAME <b>Jennie <del>Kenny</del> Mowery</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-18-2838</b>	
17. INFORMANT <b>"Wife"</b>		Address <b>Route # 2 Oakland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442x Uremia</b> DUE TO (b) <b>Cardio-renal vascular disease</b> DUE TO (c) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>5 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-1-54</b> to <b>8-13-60</b> , that (I) (we) last saw the deceased alive on <b>8-13-60</b> , and that death occurred at <b>12:00 Noon</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Andrew E. Mance</b>		22b. DATE SIGNED <b>14 Aug 60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Andrew E. Mance, M. D.,</b>		22d. ADDRESS <b>Oakland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/16/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Eglon Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Eglon, Preston Co., W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 18 '60</b>	
ADDRESS <b>Oakland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hance</b>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS AND STATISTICS  
BOSTON, MASSACHUSETTS

00184

0110

NAME OF DECEASED

DATE OF DEATH

SEX

AGE

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

Cause of Death

1

DATE OF DEATH

TIME OF DEATH

DO

DECLARATION OF DEATH  
I, the undersigned, being a duly qualified medical practitioner, do hereby certify that the above-named person has died of the cause stated above, and that the death was not due to any other cause than that stated above.

SIGNATURE OF PHYSICIAN

DATE

DECLARATION OF DEATH  
I, the undersigned, being a duly qualified medical practitioner, do hereby certify that the above-named person has died of the cause stated above, and that the death was not due to any other cause than that stated above.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



090

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Item 1d, Film 9744 G269 8/16/60 1b

9159

# CERTIFICATE OF DEATH

09133

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W.Va.</b> b. COUNTY <b>Preston</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aurora</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Evans Nursing Home</b>				d. STREET ADDRESS <b>85X-3</b>			
3. NAME OF DECEASED (Type or print) First <b>Lucy</b> Middle <b>Ellen</b> Last <b>Haas</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 9, 1882</b>	9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Alvin A. McCrum</b>				14. MOTHER'S MAIDEN NAME <b>Margret Shuttleworth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Girtrude Hardesty Aurora, W.Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Carcinomatosis</b> DUE TO <b>17 DX</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma breast</b> DUE TO (c) <b>5 yrs.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>Aug 11</b> , 19 <b>60</b> , to <b>Aug 3</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Aug 3</b> , 19 <b>60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							DATE SIGNED
ACTUAL SIGNATURE <b>Chas E Smith</b>				ADDRESS (Street, city or town, state) <b>Terra Alta W.Va.</b>			
PHYSICIAN'S NAME (Type) <b>Chas. E. Smith M.D.</b>				<b>W.Va.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 5/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Aurora</b>		22d. LOCATION (City, town, or county) <b>Aurora</b>		(State) <b>W.Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wayne C. Spiggle</b>				24a. REC'D BY REGISTRAR <b>DAUG 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Orlando J. Hunt</b>	

10137

## CERTIFICATE OF DEATH

10137

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 10/10/1873		5. PLACE OF BIRTH New York	
6. OCCUPATION Farmer		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 10/10/1895		9. NAME OF SPOUSE Mary H. Harris		10. DATE OF DEATH 10/10/1938	
11. PLACE OF DEATH Home		12. CAUSE OF DEATH Heart Disease		13. MANNER OF DEATH Natural		14. SIGNATURE OF DECEASED James H. Harris		15. SIGNATURE OF WITNESS Mary H. Harris	
16. SIGNATURE OF PHYSICIAN Dr. J. H. Harris		17. SIGNATURE OF MINISTER Rev. J. H. Harris		18. SIGNATURE OF CORONER J. H. Harris		19. SIGNATURE OF JURY J. H. Harris		20. SIGNATURE OF JUDGE J. H. Harris	

CONF.  
R.N.  
SENT

TO DEPUTY MEDICAL EXAMINER: If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

M

1

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9160 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09134											
1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGHENY</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>OAKLAND</u>					c. LENGTH OF STAY in 1b <u>13 Hrs., 45 min.</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> <u>0102-2</u>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					d. STREET ADDRESS <u>24 N. WAVERLY TERRACE</u>						
3. NAME OF DECEASED (Type or print) First <u>MAE</u> Middle <u>V.</u> Last <u>HAUSMAN</u>					4. DATE OF DEATH Month <u>AUGUST</u> Day <u>24</u> Year <u>1960</u>						
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 14, 1894</u>		9. AGE (In years last birthday) <u>66</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u> , <u>Keyser</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>			
13. FATHER'S NAME <u>MASON TUCKER</u>					14. MOTHER'S MAIDEN NAME <u>RACHEL MC NEMAR</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>  </u>						
17. INFORMANT <u>ETHEL M. KLINE, CUMBERLAND, MD.</u>					Address <u>24 N. WAVERLY TER.</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUBDURAL HEMORRHAGE, MASSIVE: LEFT</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONTUSIONS OF BRAIN, LEFT</u> DUE TO (c) <u>  </u>								INTERVAL BETWEEN ONSET AND DEATH <u>16 Hrs.</u> <u>16 Hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident at route 219 and route 50</u> <u>MV &amp; MV</u>							
20c. TIME OF INJURY Month, Day, Year <u>12:00 a.m.</u> <u>Noon 8-23, 1960</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Oakland, rural (Garrett) Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <u>James H. Feaster, Jr.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <u>August 24-60</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>August 26, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Cumberland, Maryland</u>		
23. FUNERAL DIRECTOR <u>John J. Hafer, Cumberland, Maryland</u>					24a. REC'D BY REGISTRAR <u>DATE AUG 29 '60</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1

2

# 1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9161

## 1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.

09135

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>			c. LENGTH OF STAY IN 1b <b>1 hour</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Box 74, Deer Park</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett County Memorial Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Hinebaugh</b>				<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>3</b> Year <b>19 60</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>August 3, 1960</b>		<b>9. AGE</b> (In years last birthday) yrs. <b>1</b>		<b>IF UNDER 1 YEAR</b> Months <b>1</b> Days <b>1</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) -----			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> -----		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>
<b>13. FATHER'S NAME</b> <b>Hinebaugh, Earl Thornton</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Friend, Freda Pearl</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> -----		<b>17. INFORMANT</b> Address <b>Earl T. Hinebaugh</b> <b>Deer Park, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <b>19</b> o. m. p. m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>	<b>(State)</b>
<b>21. I certify that I attended the deceased from</b> <b>August 3</b> , 19 <b>60</b> , <b>to</b> <b>August 3</b> , 19 <b>60</b> , <b>that I last saw the deceased alive on</b> <b>August 3</b> , 19 <b>60</b> , <b>and that death occurred at</b> <b>6:05 A.M.</b> , <b>from the causes and on the date stated above.</b> <b>ADDRESS</b> (Street, city or town, state) <b>Oakland, Maryland</b> <b>DATE SIGNED</b> <b>8-3-60</b> <b>ACTUAL SIGNATURE</b> <b>James H. Feaster, Jr.</b> <b>M.D.</b> <b>PHYSICIAN'S NAME (Type)</b> <b>James H. Feaster, Jr.</b> <b>M.D.</b> <b>Oakland, Maryland</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>8/4/1960</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Deer Park Cemetery</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Deer Park, Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Ad. Leighton</b>				<b>ADDRESS</b> <b>Oakland, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE AUG 8 '60</b>	<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Thomas</b>

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

00155

See Ord. 10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9162

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09136

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. LENGTH OF STAY IN 1b <b>5 HOURS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KITZMILLER</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WALTER WASHINGTON KELLER</b>				4. DATE OF DEATH Month Day Year <b>AUGUST 21, 1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 16, 1894</b>	
9. AGE (In years lost birthday) <b>66 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MINER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>COAL MINING</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>	
13. FATHER'S NAME <b>RICHARD KELLER</b>				14. MOTHER'S MAIDEN NAME <b>REBECCA STEMPLE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>712</b>				16. SOCIAL SECURITY NO. <b>216-10-1346</b>		17. INFORMANT <b>MRS. WALTER KELLER, KITZMILLER, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage- due to hypertension</b> DUE TO <b>hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at 12:20 A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Andrew E. Mance</b> M.D.				22b. ADDRESS <b>OAKLAND, MD.</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. ANDREW E. MANCE</b>	
22d. DATE <b>21 AUG 60</b>				22e. SIGNATURE <b>Robert Kyle Potts Jr.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8-23-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F.</b>	
23d. LOCATION (City, town, or county) (State) <b>514 Garden W.Va.</b>				24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert Kyle Potts Jr. Kitzmiller, Md.</b>			
25a. REC'D BY REGISTRAR <b>DATE AUG 26 '60</b>				25b. REGISTRAR'S SIGNATURE <b>Robert Kyle Potts Jr.</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9176

## CERTIFICATE OF DEATH

09137  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt# 1, Oakland</b>				c. LENGTH OF STAY IN 1b <b>13 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Carl Martin Kitzmiller</b>				4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/31.1911</b>	9. AGE (In years last birthday) yrs. <b>49</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Contracting</b>		11. BIRTHPLACE (State or foreign country) <b>Oakland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph E. Kitzmiller</b>				14. MOTHER'S MAIDEN NAME <b>Emily Lewis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-10-0510</b>		17. INFORMANT <b>Edna Hardesty, Petersburg, Fla.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>STARVATION</b> DUE TO <b>1960</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA OF STOMACH</b> (c) <b>METASTASES</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b> <b>8 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-14-1950</b> , to <b>8-22-1960</b> , that I last saw the deceased alive on <b>8-20-1960</b> , and that death occurred at <b>5 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>James H. Feaster, Jr. M.D. 58 East Oakland Rd 8-23-60</b>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>JAMES H. FEASTER, JR. M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>8/24/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oakland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gerald N. Minnich</b>				ADDRESS <b>Oakland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 26 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Carroll S. Kline</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

9163

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09138

1. PLACE OF DEATH o. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. LENGTH OF STAY IN 1b <b>1 Day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT. LAKE PARK, MARYLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT CO. MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>HENRY</b> Last <b>KITZMILLER</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>4</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 27, 1881</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>9</b> Hours <b>10</b> Min.		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own FARM</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>WILLIAM KITZMILLER</b>				14. MOTHER'S MAIDEN NAME <b>AIRY ANN BACHTEL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>212-24-0631</b>		17. INFORMANT <b>(ADA KITZMILLER) WIFE</b> Address <b>MT. LAKE PARK, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarct of brain-stem</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute coronary thrombosis + hypotension</b> DUE TO <b>2 days</b> (c) <b>Arteriosclerotic heart disease</b> DUE TO <b>10 yrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>2 days</b> <b>10 yrs.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>8/30, 1960</b> to <b>8/4, 1960</b> , that (I) (we) last saw the deceased alive on <b>8/4, 1960</b> , and that death occurred at <b>7:15 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard A. Leighton</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/5/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. RICHARD LEIGHTON M. D.</b>				22d. ADDRESS <b>OAKLAND, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8/6/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Valley Cemetery Garrett Co., Md.</b>	
23d. LOCATION (City, town, or county) (State) <b>Garrett Co., Md.</b>				23e. LOCATION (City, town, or county) (State) <b>Garrett Co., Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Leighton</b>				ADDRESS <b>Oakland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 8 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Prouse</b>				25c. REGISTRAR'S SIGNATURE <b>Arthur S. Prouse</b>			

BP

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CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

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DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

9164

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09139

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN lb 4 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JACOB Middle ANDREW Last LANDIS		4. DATE OF DEATH Month AUGUST Day 5 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 1, 1881
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10. OCCUPATION (Give kind of work done during most of working life, even if retired) Forest Service		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME LANDIS, GEORGE W	
14. MOTHER'S MAIDEN NAME KIMBLE, HANNAH		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 232-26-3528		17. INFORMANT Address BERTHA D. SIMMONS, MT. LAKE PARK, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Pneumonia, bilateral, bacterial (b) Peritonitis due to ruptured peptic ulcer (c) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 8 Feb 1955 to 5 Aug 1960 that (I) (we) last saw the deceased alive on 5 Aug 1960, and that death occurred at 2:00 A.M. from the causes and on the date stated above. 22a. SIGNATURE Andrew E. Mance M.D. 22c. PHYSICIAN'S NAME (Type) DR. ANDREW E. MANCE 22d. ADDRESS OAKLAND, MD. 22e. DATE 8/6/60 22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/7/1960	
23c. NAME OF CEMETERY OR CREMATORY Mayesville Cemetery		23d. LOCATION (City, town, or county) (State) Grant County, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. Leighton Oakland, Md.		25a. REC'D BY REGISTRAR DATE AUG 8 '60	
25b. REGISTRAR'S SIGNATURE Andrew E. Mance			

0813

CERTIFICATE OF DEATH

1161

1161

1

833-33-333

01/1930

11/1930

01/1930

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9165

## CERTIFICATE OF DEATH

Reg. Dist. No. 49140

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland,</b>				c. LENGTH OF STAY IN 1b <b>3 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Oak Rest Nursing Home</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Deer Park,</b>			
				d. STREET ADDRESS <b>2 Mi. S. Deer Park, Md.</b>			
3. NAME OF DECEASED (Type or print) First <b>Nora</b> Middle <b>Haden</b> Last <b>Landis</b>				4. DATE OF DEATH Month <b>August</b> Day <b>26,</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1889</b>		9. AGE (In years last birthday) yrs. <b>71</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John W. Landis</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Shirk</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>no</b>		16. SOCIAL SECURITY NO. <b>----</b>		17. INFORMANT <b>Harold R. Landis</b> Address <b>Deer Park, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unk. d</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardio -</b> DUE TO <b>Renal Disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>YEARS</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1959</b> , 19 <b>8.24</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>8.24</b> , 19 <b>60</b> , and that death occurred at <b>1:05P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James H. Feaster Jr.</b>				ADDRESS (Street, city or town, state) <b>58 24 St. Oakland, Md.</b>		DATE SIGNED <b>8.28.60</b>	
PHYSICIAN'S NAME (Type) <b>James H. Feaster Jr., M. D.</b>				Oakland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/29/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>King Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>near Loch Lynn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A.C. Lightfoot</b> ADDRESS <b>Oakland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 09141

1. PLACE OF DEATH a. COUNTY <i>Garrett</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Garrett</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural- Grantsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural- Grantsville</i>	
c. LENGTH OF STAY IN 1b <i>3 weeks</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Noah</i> Middle <i>J</i> Last <i>Lee</i>		4. DATE OF DEATH Month <i>8</i> Day <i>22</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 20, 1878</i>
9. AGE (In years last birthday) <i>81</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <i>Arthur, Illinois</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John T Lee</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Yoder</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic myocardial failure</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) <i>1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i> <i>10 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 10, 1960</i> , to <i>Aug 22, 1960</i> , that I last saw the deceased alive on <i>Aug 21, 1960</i> , and that death occurred at <i>9:20 AM</i> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>A. Paige Strong</i> M.D. <i>Grantsville, Md</i>		<i>8/23/60</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-25-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Niverton Amish Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Salisbury Rd Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.P. Conhays</i>		ADDRESS <i>Meyersdale Pa.</i>	
24a. REC'D BY REGISTRAR <i>AUG 30 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH BALTIMORE		DATE OF DEATH JAN 10 1900	
NAME OF DECEASED JOHN J. WATSON		AGE 45	
SEX Male		RACE White	
BIRTH DATE JAN 10 1855		BIRTH PLACE BALTIMORE	
MARRIED Yes		WIFE'S NAME MARY J. WATSON	
OCCUPATION Carpenter		EDUCATION High School	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF BURIAL JAN 12 1900		PLACE OF BURIAL St. Mary's Cemetery	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF MINISTER [Signature]	
SIGNATURE OF CORONER [Signature]		SIGNATURE OF JURY [Signature]	
SIGNATURE OF DEPUTY CLERK [Signature]		SIGNATURE OF CLERK [Signature]	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF BALTIMORE, IN THE CASE OF THE ESTATE OF THE DECEASED, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE COUNTY OF BALTIMORE, IN THE CASE OF THE ESTATE OF THE DECEASED.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9166

CERTIFICATE OF DEATH

09143

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland,</b>		c. LENGTH OF STAY IN 1b <b>40 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mason Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Gordon</b> Middle <b>Drydan</b> Last <b>McRobie</b>		4. DATE OF DEATH Month <b>August</b> Day <b>28</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 1, 1894</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Appliance service West Md. Power Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph H. McRobie</b>		14. MOTHER'S MAIDEN NAME <b>Clara Kreeland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W. W. #1 215-01-9071</b>	
17. INFORMANT <b>Mrs. Elizabeth McRobie</b>		Address <b>Oakland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIO SCLEROSIS</b> DUE TO (c) <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ANXIETY NEOROSIS - 5 yrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/20/46</b> 19____, to <b>8/28/60</b> 19____, that I last saw the deceased alive on <b>8/27/60</b> 19____, and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. I. Baumgartner</b>		M.D. <b>2522 DEN ST</b> ADDRESS (Street, city or town, state) <b>Oakland, Md.</b> DATE SIGNED <b>8/29/60</b>	
PHYSICIAN'S NAME (Type) <b>E. I. Baumgartner, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/31/1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Oakland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. L. Leighton</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



9178

## CERTIFICATE OF DEATH

Reg. Dist. No. 09144

1. PLACE OF DEATH o. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL GRANTSVILLE LIFE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL GRANTSVILLE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHRISTOPHER</b> First <b>MERRBACH</b> Middle <b>MEYER</b> Last				4. DATE OF DEATH Month <b>AUG.</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 19, 1886</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COAL MINES</b>		11. BIRTHPLACE (State or foreign country) <b>FROSTBURG MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>HENRY MERRBACH</b>				14. MOTHER'S MAIDEN NAME <b>CHRISTINA BOWERS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>196-22-0735</b>		INFORMANT Address <b>Mrs. Annie Spicker, Laboratory Rd. Pg.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Acute Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <b>Arteriosclerotic Heart disease</b> lying cause lost. } DUE TO (c) <b>with Congestive failure</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/11</b> , 19 <b>60</b> to <b>8/3</b> , 19 <b>60</b> that I last saw the deceased alive on <b>8/1</b> , 19 <b>60</b> , and that death occurred at <b>8:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>345 Main St Meyersdale Pa</b> DATE SIGNED							
ACTUAL SIGNATURE <b>D. C. Glassman M.D.</b>				PHYSICIAN'S NAME (Type) <b>D. C. Glassman</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/6/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MERRBACH</b>		22d. LOCATION (City, town, or county) (State) <b>GARRETT Co MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Don J. Harrison</b>				ADDRESS <b>Grantsville Md</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 8 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-10

CERTIFICATE OF DEATH

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(M)

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# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Div. of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Deer Park</b> c. LENGTH OF STAY IN TB <b>30 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>R. D., 5 Mi. S. Deer Park, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Deer Park</b> d. STREET ADDRESS <b>R. D., Deer Park, Md.</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Albert Manuel Moon</b>		4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 8, 1890</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer &amp; Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Solomon Moon</b>		14. MOTHER'S MAIDEN NAME <b>Anna Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-12-8917</b>	
17. INFORMANT <b>George Moon (Son)</b>		Address <b>Deer Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decapitation secondary to self inflicted gunshot wound of head</b> DUE TO (b) <b>inflicted gunshot wound of head</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self in head with .30-.30 cal. soft nose rifle slug</b>	
20c. TIME OF INJURY Month, Day, Year <b>Aug. 9, 1960</b> Hour <b>10:30</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Residence</b>	20f. (City or town) <b>Garrett</b> (County) <b>Garrett</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>8/10/60</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ADDRESS (Street, city, town, or county) <b>Oakland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/12/1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Henry Beckman Cemetery near Mt. Lake Park, Md.</b>	22d. LOCATION (City, town, or county) (State) <b>Oakland, Md.</b>
23. FUNERAL DIRECTOR <i>H.C. Leighton</i>		24a. REC'D BY REGISTRAR <b>AUG 15 '60</b>	
ADDRESS <b>Oakland, Md.</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

Unpleasant wound of hand  
Necessity to self



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

9167

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09146

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>28 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett County Memorial Hospital</b>				d. STREET ADDRESS <b>52 Pennington St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>E.</b> Last <b>Naylor Sr.</b>				4. DATE OF DEATH Month <b>August</b> Day <b>11</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-25-1890</b>		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Hardware</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>America U.S.A.</b>	
13. FATHER'S NAME <b>Alonzo D. Naylor</b>				14. MOTHER'S MAIDEN NAME <b>Artie Bartlett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>"Wife" Ruth M. Naylor,</b>		Address <b>52 Pennington St. Oakland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>525X</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <b>Pulmonary Embolism</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphysema</b>						INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> 19 to <b>Aug 11</b> 19 <b>60</b> , that (I) <del>was</del> last saw the deceased alive on <b>Aug 11</b> 19 <b>60</b> , and that death occurred on <b>9:12A</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>James H. Feaster Jr.</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/12/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>James H. Feaster Jr., M. D.,</b>				22d. ADDRESS <b>Oakland, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/13/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Oakland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b>				ADDRESS <b>Oakland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 15 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneiss</b>	

1914

OFFICE OF DEATH

1914

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in no event within 72 hours after death.

VR A15 (4)  
ISM 9/59

9168

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09147

Items 8, 9 Film 270 9-7-60 et

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN lb <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WARDER</b> Middle <b>REESE</b> Last <b>NETHKEN</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>7</b> Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1878</b> <b>SEPTEMBER 2, 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COAL BROKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brokage</b>	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NETHKEN, JOSEPH</b>		14. MOTHER'S MAIDEN NAME <b>BRANT, Clara Brandt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-03-8859</b>	
17. INFORMANT <b>CAROLINE NETHKEN</b>		Address <b>1929 PARK AVE, BALTIMORE 17, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular Disorder</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 5</b> 19 <b>60</b> , to <b>Aug 7</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Aug 7</b> 19 <b>60</b> , and that death occurred at <b>11:25 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>E. I. Baumgartner</b>		22b. DATE SIGNED <b>8/7/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. E. I. BAUMGARTNER</b>		22d. ADDRESS <b>OAKLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>8/9/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Gerard J. Minnich</b>		25a. REC'D BY REGISTRAR <b>AUG 10 '60</b>	
ADDRESS <b>Oakland, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

00117

CERTIFICATE OF DEATH

3162



Regional Health Director  
State of California

00117

State of California

Official State Registrar  
Oakland, California

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9180

CERTIFICATE OF DEATH

09148

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Deer Park,</b> c. LENGTH OF STAY IN 1b <b>10 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Point, Deep Creek Lake</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Deer Park,</b> d. STREET ADDRESS <b>Pen Point, Deep Creek Lake</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Jennings</b> Last <b>Ritchey</b>		4. DATE OF DEATH Month <b>August</b> Day <b>20,</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1897</b> 9. AGE (In years last birthday) <b>65</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired, Owner Auto Tire Sales</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William C. Ritchey</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Jay</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give year or dates of service) <b>W.W.#1</b>		16. SOCIAL SECURITY NO. <b>163-10-4589</b>	
17. INFORMANT (Wife) <b>Esther Mae Ritchey</b>		Address <b>Deer Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> (c) <b>15 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9/11/52</b> to <b>8/20/60</b> , that I last saw the deceased alive on <b>8/20/60</b> , and that death occurred at <b>1:30P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Andrew E. Mance</b> M.D.		ADDRESS (Street, city or town, state) <b>Oakland Md</b> DATE SIGNED <b>21 Aug 60</b>	
PHYSICIAN'S NAME (Type) <b>Andrew E. Mance, M. D.</b>		<b>Oakland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/22/1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Deer Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Deer Park, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. L. Leighton</b> ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 26 1960</b>	24b. REGISTRAR'S SIGNATURE <b>Andrew E. Mance</b>

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u> years</p>	
<p>4. Date of death: <u>Jan 15, 1920</u></p>	
<p>5. Place of death: <u>Home</u></p>	
<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Signature of physician: <u>Dr. J. H. Smith</u></p>	
<p>8. Signature of registrar: <u>John Doe</u></p>	
<p>9. Date of registration: <u>Jan 15, 1920</u></p>	
<p>10. Place of registration: <u>Baltimore</u></p>	
<p>11. Name of informant: <u>John Doe</u></p>	
<p>12. Address of informant: <u>123 Main St.</u></p>	
<p>13. City: <u>Baltimore</u></p>	
<p>14. State: <u>Md.</u></p>	
<p>15. County: <u>Baltimore</u></p>	
<p>16. District: <u>1st</u></p>	
<p>17. Ward: <u>1st</u></p>	
<p>18. Block: <u>1st</u></p>	
<p>19. Lot: <u>1st</u></p>	
<p>20. Sublot: <u>1st</u></p>	
<p>21. Section: <u>1st</u></p>	
<p>22. Subsection: <u>1st</u></p>	
<p>23. Block: <u>1st</u></p>	
<p>24. Lot: <u>1st</u></p>	
<p>25. Sublot: <u>1st</u></p>	
<p>26. Section: <u>1st</u></p>	
<p>27. Subsection: <u>1st</u></p>	
<p>28. Block: <u>1st</u></p>	
<p>29. Lot: <u>1st</u></p>	
<p>30. Sublot: <u>1st</u></p>	
<p>31. Section: <u>1st</u></p>	
<p>32. Subsection: <u>1st</u></p>	
<p>33. Block: <u>1st</u></p>	
<p>34. Lot: <u>1st</u></p>	
<p>35. Sublot: <u>1st</u></p>	
<p>36. Section: <u>1st</u></p>	
<p>37. Subsection: <u>1st</u></p>	
<p>38. Block: <u>1st</u></p>	
<p>39. Lot: <u>1st</u></p>	
<p>40. Sublot: <u>1st</u></p>	
<p>41. Section: <u>1st</u></p>	
<p>42. Subsection: <u>1st</u></p>	
<p>43. Block: <u>1st</u></p>	
<p>44. Lot: <u>1st</u></p>	
<p>45. Sublot: <u>1st</u></p>	
<p>46. Section: <u>1st</u></p>	
<p>47. Subsection: <u>1st</u></p>	
<p>48. Block: <u>1st</u></p>	
<p>49. Lot: <u>1st</u></p>	
<p>50. Sublot: <u>1st</u></p>	
<p>51. Section: <u>1st</u></p>	
<p>52. Subsection: <u>1st</u></p>	
<p>53. Block: <u>1st</u></p>	
<p>54. Lot: <u>1st</u></p>	
<p>55. Sublot: <u>1st</u></p>	
<p>56. Section: <u>1st</u></p>	
<p>57. Subsection: <u>1st</u></p>	
<p>58. Block: <u>1st</u></p>	
<p>59. Lot: <u>1st</u></p>	
<p>60. Sublot: <u>1st</u></p>	
<p>61. Section: <u>1st</u></p>	
<p>62. Subsection: <u>1st</u></p>	
<p>63. Block: <u>1st</u></p>	
<p>64. Lot: <u>1st</u></p>	
<p>65. Sublot: <u>1st</u></p>	
<p>66. Section: <u>1st</u></p>	
<p>67. Subsection: <u>1st</u></p>	
<p>68. Block: <u>1st</u></p>	
<p>69. Lot: <u>1st</u></p>	
<p>70. Sublot: <u>1st</u></p>	
<p>71. Section: <u>1st</u></p>	
<p>72. Subsection: <u>1st</u></p>	
<p>73. Block: <u>1st</u></p>	
<p>74. Lot: <u>1st</u></p>	
<p>75. Sublot: <u>1st</u></p>	
<p>76. Section: <u>1st</u></p>	
<p>77. Subsection: <u>1st</u></p>	
<p>78. Block: <u>1st</u></p>	
<p>79. Lot: <u>1st</u></p>	
<p>80. Sublot: <u>1st</u></p>	
<p>81. Section: <u>1st</u></p>	
<p>82. Subsection: <u>1st</u></p>	
<p>83. Block: <u>1st</u></p>	
<p>84. Lot: <u>1st</u></p>	
<p>85. Sublot: <u>1st</u></p>	
<p>86. Section: <u>1st</u></p>	
<p>87. Subsection: <u>1st</u></p>	
<p>88. Block: <u>1st</u></p>	
<p>89. Lot: <u>1st</u></p>	
<p>90. Sublot: <u>1st</u></p>	
<p>91. Section: <u>1st</u></p>	
<p>92. Subsection: <u>1st</u></p>	
<p>93. Block: <u>1st</u></p>	
<p>94. Lot: <u>1st</u></p>	
<p>95. Sublot: <u>1st</u></p>	
<p>96. Section: <u>1st</u></p>	
<p>97. Subsection: <u>1st</u></p>	
<p>98. Block: <u>1st</u></p>	
<p>99. Lot: <u>1st</u></p>	
<p>100. Sublot: <u>1st</u></p>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 9169 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09149

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN lb <b>23 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett C. Memorial Hosp.</b>				d. STREET ADDRESS <b>Rt. 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anna May Schoch</b>				4. DATE OF DEATH Month <b>8</b> Day <b>1</b> Year <b>19 60</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-17-1896</b>		9. AGE (In years last birthday) <b>64 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Terra Alta, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James B. Nordeck</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Riley</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>----</b>		17. INFORMANT <b>Mrs. Geraldine Glotfelty</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cereberal hemorrhage into brain tumor</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) <b>Fell out of bed at home 6-15-60, unk. 1f head struck.</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>Oakland, Md. 8-2-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>8/3/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Oakland Md.</b>	
23. FUNERAL DIRECTOR <b>Gerald N. Minnich</b> ADDRESS <b>Oakland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

MEDICAL CERTIFICATION

FOR STATE  
WILLIAM H. DAVIS  
(M)

9103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

State of Maryland  
County of Prince George's  
City of Alexandria  
James S. Davis  
Age 55 yrs  
Born 1-17-1888  
U. S. A.  
Cause of death  
Certificate of death  
3 weeks

Full set of records 15-60, and 15-60-60

James S. Davis, Jr., M.D., Secretary, U. S. Department of Health

001-100  
001-100

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

9170

09150

1. PLACE OF DEATH a. COUNTY <b>Garrett County, MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>				c. LENGTH OF STAY IN b. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>29 Hrs. 48 Min. Rural, Swanton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett County Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Judy</b> Middle <b>Kay</b> Last <b>Sharpless</b>				4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 21, 1960</b>		9. AGE (In years lost birthday) yrs. <b>29</b>	IF UNDER 1 YEAR Months <b>29</b> Days <b>48</b>	IF UNDER 24 HRS. Hours <b>29</b> Min. <b>48</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newborn</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland (Oakland)</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Clarence E. Sharpless</b>				14. MOTHER'S MAIDEN NAME <b>Alice Victoria Turner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Clarence E. Sharpless, Box 146, R.#1, Swanton, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity (2 Lbs 10 oz)</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>29 48 Hrs</b> <b>60</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>8-21</b> 19 <b>60</b> , to <b>8-22</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>8-22</b> 19 <b>60</b> , and that death occurred at <b>8:40 P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>James H. Feaster, Jr., M.D.</b>				22b. DATE SIGNED <b>8-22-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>James H. Feaster, Jr., M.D.</b>				22d. ADDRESS <b>Oakland, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 23/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Turner Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>near Swanton, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Amy M. Sharpless</b>				ADDRESS <b>Blaine, W. Va.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 24 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>William S. Turner</b>			

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TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FWS-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9181 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09151

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE W. Va. b. COUNTY HAMPSHIRE	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BLOOMINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEVELS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) -		d. STREET ADDRESS 85X-3	
3. NAME OF DECEASED (Type or print) GLENN MORELAND SNYDER		4. DATE OF DEATH AUG. 2ND. 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1934
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY W. Va.	
13. FATHER'S NAME CHARLES GEORGE SNYDER		14. MOTHER'S MAIDEN NAME MARY ELLEN MORELAND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) No		16. SOCIAL SECURITY NO. 235-56-3523	
17. INFORMANT Mr. Charles Snyder,		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURED SKULL 816X DUE TO CRUSHED CHEST Conditions, if any, which gave rise to immediate cause (b) BROKEN LEFT ARM (a), stating the underlying cause last. DUE TO MULTIPLE EXTENSIVE CHEMICAL BURNS (c)		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE II II II	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Deceased was asleep in his parked truck which in turn was struck by a runaway chemical truck Rt. 135, Bloomington, Md.	
20c. TIME OF INJURY Month, Day, Year 5:05 a.m. AUG. 2 19 60		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Bloomington, Garr., Mdd. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James H. Feaster, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES H. FEASTER, JR., M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/5/60	
22c. NAME OF CEMETERY OR CREMATORY Levels Cemetery		22d. LOCATION (City, town, or country) Levels, W. Va. (State)	
23. FUNERAL DIRECTOR E. S. Boral - Westernport, Md		24a. REC'D BY REGISTRAR DATE AUG 4 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>1</span> <span>9171</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> </div> <div style="display: flex; justify-content: space-between;"> <span></span> <span>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</span> <span>09152</span> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">             CERTIFICATE OF DEATH         </div>										
<b>1. PLACE OF DEATH</b> a. COUNTY <u>GARRETT</u> <span style="float: right;">MARYLAND</span>					<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> <span style="float: right;">b. COUNTY <u>GARRETT</u></span>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND</u>			c. LENGTH OF STAY IN lb <u>5 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEER PARK</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>					d. STREET ADDRESS <u>1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <u>RICHARD</u> Middle <u>SOLLARS</u> Last <u>SOLLARS</u>					<b>4. DATE OF DEATH</b> Month <u>AUGUST</u> Day <u>14</u> Year <u>1960</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>FEBRUARY 16, 1883</u>		9. AGE (In years last birthday) <u>77</u> yrs.		
						IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal MINER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Soft Coal Mines</u>		11. BIRTHPLACE (State or foreign country) <u>ELK GARDEN, W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>THOMAS SOLLARS</u>					14. MOTHER'S MAIDEN NAME <u>JANE JUNKINS</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-03-7217</u>		17. INFORMANT <u>MARGARET SOLLARS</u> <span style="float: right;">Address <u>DEER PARK, MARYLAND</u></span>						
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;">                     PART I. DEATH WAS CAUSED BY:                      IMMEDIATE CAUSE (a) <u>Pulmonary Edema + Bilateral</u>  <u>592X</u> DUE TO                      (b) <u>Cor Pulmonale</u>                      Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Chronic Glomerulonephritis</u>                      DUE TO                 </div> <div style="width: 15%;">                     INTERVAL BETWEEN ONSET AND DEATH  <u>1 Month</u>  <u>5 years</u>  <u>Unknown</u> </div> </div>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>March 1957</u> to <u>Aug 14, 1960</u> , that (I) (we) last saw the deceased alive on <u>Aug 14, 1960</u> , and that death occurred at <u>4:15 A.M.</u> from the causes and on the date stated above.										
22a. SIGNATURE <u>Herbert H. Leighton</u>					22b. DATE SIGNED <u>14 Aug. 60</u>					
22c. PHYSICIAN'S NAME (Type) <u>Herbert H. Leighton, M.D.</u>					22d. ADDRESS <u>77 Oak Street, Oakland, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/17/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Deer Park, Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. Leighton</u>					ADDRESS <u>Oakland, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 18 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

9172

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

09153

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. LENGTH OF STAY IN 1b <b>25 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT CO. MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LEWIS</b> Middle <b>LEE</b> Last <b>STEWART</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>7</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 14, 1890</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>7</b>		11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ROWLESBURG, W. VA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>SANFORD STEWART</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH SUSAN SYPODT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>(MABEL STEWART WIFE) HUTTON, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> DUE TO <b>Advanced Myocardial Arteriosclerosis</b> Cause (b) <b>Sterile Heart Disease</b> DUE TO <b></b> Cause (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Thrombocytopenic Purpura - Hypochromic Anemia</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>7/10/60</b> 19 <b></b> , to <b>8/7/60</b> 19 <b></b> , that (I) (we) last saw the deceased alive on <b>8/6/60</b> 19 <b></b> , and that death occurred at <b>8:55 A.M.</b> the causes and on the date stated above.							
22a. SIGNATURE <b>E. I. Baumgartner</b>				22b. DATE SIGNED <b>8/7/60</b>		22c. PHYSICIAN'S NAME (Type) <b>E. I. BAUMGARTNER M. D.</b>	
22d. ADDRESS <b>OAKLAND, MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal &amp; Burial</b>		23b. DATE THEREOF <b>8/10/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Terra Alta Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Terra Alta, West Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Md. F.D. License A8305</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 12 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

MEDICAL CERTIFICATION

1215

STATE OF TEXAS

1215

(M)

(1)

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "STATE OF TEXAS" and "COUNTY OF" are faintly visible.]*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09154  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Friendsville, Md.</b>				c. LENGTH OF STAY IN 1b <b>all of life</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Friendsville, Md.</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>none</b>			
d. STREET ADDRESS <b>none</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Manilla</b> Middle <b>Gladys</b> Last <b>Thomas Umble</b>				4. DATE OF DEATH Month <b>August</b> Day <b>23</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 28, 1899</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>23</b> Days <b>23</b> Hours <b>1960</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Hosea Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Ida Belle Thomas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Chlen Umble</b> Address <b>Friendsville, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Gall Bladder</b> DUE TO <b>155</b> Conditions, if any, which gave rise to immediate cause (b), (c) <b>Metastases to Liver, Intestines, Lung 1 yr ago.</b> DUE TO <b>(operation July 1, 60 Bishop taken)</b> DUE TO <b>Ca.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) <b>Secondary Anemia</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs ago</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 15, 1960</b> , to <b>Aug 23, 1960</b> , that I last saw the deceased alive on <b>Aug 22, 1960</b> , and that death occurred at <b>3 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edwin M. Price MD</b>				ADDRESS (Street, city or town, state) <b>612 Logan Place Confluence Pa</b>			
PHYSICIAN'S NAME (Type) <b>Edwin M. Price MD</b>				DATE SIGNED <b>Pa</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/26/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sand Spring Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Garrett Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Estimate Brandonville</b>				24a. REC'D BY REGISTRAR <b>SEP 6 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE	
MARRIED		1905		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		1905		BALTIMORE		BALTIMORE	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		DATE OF GRADUATION		PLACE OF GRADUATION		CITY OF GRADUATION		STATE OF GRADUATION		COUNTRY OF GRADUATION	
HIGH SCHOOL		BALTIMORE		BALTIMORE		BALTIMORE		1900		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
OCCUPATION		BUSINESS		MANAGER		DATE OF OCCUPATION		PLACE OF OCCUPATION		CITY OF OCCUPATION		STATE OF OCCUPATION		COUNTRY OF OCCUPATION		DATE OF OCCUPATION	
BUSINESS		MANAGER		DATE OF OCCUPATION		PLACE OF OCCUPATION		CITY OF OCCUPATION		STATE OF OCCUPATION		COUNTRY OF OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION	
DATE OF DEATH		1925		10		1925		10		1925		10		1925		10	
PLACE OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
CITY OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
STATE OF DEATH		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND	
COUNTRY OF DEATH		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES	
CAUSE OF DEATH		HEART DISEASE		CORONARY ARTERY DISEASE		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH		CITY OF CAUSE OF DEATH		STATE OF CAUSE OF DEATH		COUNTRY OF CAUSE OF DEATH		DATE OF CAUSE OF DEATH	
HEART DISEASE		CORONARY ARTERY DISEASE		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH		CITY OF CAUSE OF DEATH		STATE OF CAUSE OF DEATH		COUNTRY OF CAUSE OF DEATH		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH	
DATE OF CAUSE OF DEATH		1925		10		1925		10		1925		10		1925		10	
PLACE OF CAUSE OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
CITY OF CAUSE OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
STATE OF CAUSE OF DEATH		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND	
COUNTRY OF CAUSE OF DEATH		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES	
DATE OF DEATH		1925		10		1925		10		1925		10		1925		10	
PLACE OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
CITY OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
STATE OF DEATH		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND	
COUNTRY OF DEATH		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

9173

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09155

<b>1. PLACE OF DEATH</b> a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Mt. Oakland, RK, MARYLAND</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT CO. MEMORIAL HOSPITAL</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>GILBERT</b> Middle <b>CARROLL</b> Last <b>WEIMER</b>			<b>4. DATE OF DEATH</b> Month <b>AUGUST</b> Day <b>1</b> Year <b>1960</b>		
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>26-1879</b> <b>OCT. xxxxxx</b>		<b>9. AGE</b> (In years last birthday) <b>80</b> yrs.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>TELEMAN</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>WOODS</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND</b>	
<b>13. FATHER'S NAME</b> <b>JESSE WEIMER</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>			<b>17. INFORMANT</b> (If yes, give war or dates of service) <b>(MARY E. WEIMER) BOX #252 MT. LAKE PARK, MD.</b>		
<b>16. SOCIAL SECURITY NO.</b> <b>218-01-6000</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>ELIZABETH FRIEND</b>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Terminal</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Arteriosclerotic CVD</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>Sym</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			<b>20f. (City or town) (County) (State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from 7-19 1955, to 7-31 1960 that (I) (we) last saw the deceased alive on 7-31 1960, and that death occurred at 9:05 M, from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <b>Andrew E. Mance</b>			<b>22b. DATE SIGNED</b> <b>1 Aug 60</b>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>ANDREW E. MANCE M. D.</b>			<b>22d. ADDRESS</b> <b>OAKLAND, MARYLAND</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>8/3/1960</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Ferndale Cemetery</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>H. E. Leighton</b>		<b>ADDRESS</b> <b>Oakland, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE AUG 4 '60</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kline</b>					

5173

CERTIFICATE OF DEATH

5173



James, Thomas

James, Thomas

1917

1917-10-10

CHIEF CLERK

CHIEF CLERK

CHIEF CLERK

CHIEF CLERK

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CHIEF CLERK

CHIEF CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09156

9183

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write <b>Rural</b> and give nearest town) <b>Rural Deer Park,</b>				c. CITY OR TOWN (If outside corporate limits, write <b>RURAL</b> and give nearest town) <b>Rural Deer Park,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R. D. 5 Mi. N. Deer Park, Md.</b>				d. STREET ADDRESS <b>R. D. 5 Mi. N. Deer Park</b>			
3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>Everett</b> Last <b>Wright</b>				4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 3, 1887</b>	
9. AGE (In years birthday) yrs. <b>73</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Wood Working</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>	
13. FATHER'S NAME <b>John A. Wright</b>				14. MOTHER'S MAIDEN NAME <b>Flora McRobie</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-10-1025</b>		17. INFORMANT <b>Mrs. Emma Wright</b> Address <b>R. D. Deer Park, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Hemorrhage with rt sided paralysis</b> DUE TO <b>Hypertension</b> (c) <b>5 yrs.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>(2 weeks) Aug 7 '60</b> <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>55</b> to <b>August 21, 1960</b> , that I last saw the deceased alive on <b>Aug 20</b> , 19 <b>60</b> , and that death occurred at <b>5:00A</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Kitzmill, Md.</b> DATE SIGNED <b>Aug 22-60</b> ACTUAL SIGNATURE <b>Ralph Calandrella</b> M.D. <b>Kitzmill, Md.</b> PHYSICIAN'S NAME (Type) <b>Ralph Calandrella, M. D.</b> <b>Kitzmill, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/23/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>George Cemetery</b>		22d. LOCATION (City, town, or county) <b>near Swanton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Al L. Leighton</b> ADDRESS <b>Oakland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>William S. House</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
 CERTIFICATE OF DEATH  
 1913

NAME OF DECEASED JOHN A. [illegible]		SEX Male	
AGE 35		DATE OF BIRTH [illegible]	
PLACE OF BIRTH [illegible]		OCCUPATION [illegible]	
MARITAL STATUS Married		DATE OF MARRIAGE [illegible]	
NAME OF SPOUSE [illegible]		PLACE OF BIRTH [illegible]	
NAME OF DECEASED [illegible]		SEX Female	
AGE [illegible]		DATE OF BIRTH [illegible]	
PLACE OF BIRTH [illegible]		OCCUPATION [illegible]	
MARITAL STATUS [illegible]		DATE OF MARRIAGE [illegible]	
NAME OF SPOUSE [illegible]		PLACE OF BIRTH [illegible]	
NAME OF DECEASED [illegible]		SEX Male	
AGE [illegible]		DATE OF BIRTH [illegible]	
PLACE OF BIRTH [illegible]		OCCUPATION [illegible]	
MARITAL STATUS [illegible]		DATE OF MARRIAGE [illegible]	
NAME OF SPOUSE [illegible]		PLACE OF BIRTH [illegible]	

This certificate is to be filled out by the attending physician or the coroner, and is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

[Signature]

[Stamp: RECEIVED]